IS THE AFFORDABLE CARE ACT REALLY AFFORDABLE?

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ABSTRACT
The Patient Protection and Affordable Care Act (PPACA) is a U.S. federal statute signed into law on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The Act is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of healthcare. It provides a number of mechanisms, including mandates, subsidies and tax credits to employers and individuals to increase the coverage rate. Additional reforms aim to improve healthcare outcomes and streamline the delivery of healthcare. On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of most of the Affordable Care Act (ACA) in the case National Federation of Independent Business v. Sebelius. This paper examines the mandates as well as the tax implications of this legislation, with the goal of understanding the dimensions of this vast legislation, the parties impacted and compliance requirements. We provide an overview of what must be done to comply with its complex requirements.

INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) is a U.S. federal statute signed into law on March 23, 2010. Together with the Health Care and Education Reconciliation Act (HCERA), which was signed into law on March 30, 2010, it represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The Affordable Care Act (ACA or "The Act") contains numerous provisions and requirements that impact individuals, insurers, businesses and states. Some of its provisions have had immediate impact and have been well received by the public at large, while many other mandates are highly questionable and have received intensive criticism. For example, The Act requires group health plans and health insurance issuers that provide dependent coverage of children to continue to make such coverage available for an adult child until the age of 26. The Act also amends the Internal Revenue Code (IRC) to give certain favorable tax treatment of such coverage. Other provisions of the IRC were affected by The Act namely, §10909(a)(1) of PPACA which increased the maximum adoption credit and the maximum adoption assistance exclusion from $12,170 to $13,170. It should be noted these the tax benefits phase out for taxpayers with adjusted gross income above certain thresholds.

The Act is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of healthcare. The U.S. Department of Health and Human Services (HHS), headed by Secretary Kathleen Sebelius, promotes the legislation indicating that it strengthens and

modernizes healthcare. According to HHS, The Act makes health insurance coverage more secure and reliable for those who have it. It makes coverage more affordable for families and small business owners and it brings down skyrocketing healthcare costs that have put a strain on individuals, families, employers and the federal budget. The Secretary proceeds to explain via five stated goals, each supported by numerous objectives, how it intends to improve the healthcare environment.

To achieve its goal of increasing the rate of health insurance coverage, the legislation provides a number of mechanisms, including mandates, subsidies and tax credits to employers and individuals. The Act (P.L. 111-148) takes an *overall approach* to expanding access to coverage. It requires most U. S. citizens and legal residents to have health insurance. Delivery of healthcare coverage is offered through state-based American Health Benefit Exchanges through which individuals can purchase coverage. Premium and cost-sharing credits are available to individuals and families with income between 133% to 400% of the federal poverty level (FPL). The poverty level for a family of three in 2013 is $19,530. Separate Exchanges are also created through which small business can purchase coverage. The Act requires employers to pay penalties for employees who receive tax credits for health insurance through an Exchange. There are exceptions for small employers. The Act also imposes new regulations on health plans in the Exchanges and in the individual and small group markets.

The *individual mandate* requires coverage as mentioned previously, so those without coverage will pay a tax penalty. The penalty phases in as follows: $95 in 2014, $325 in 2015 and $695 in 2016. There are also 1%, 2% and 2.5% of taxable income calculations inherent in the penalties for 2014, 2015 and 2016, respectively. After 2016, the penalty is increased for cost-of-living adjustment annually. There will also be exemptions for financial hardship, religious objections, American Indians, undocumented immigrants, those without coverage for less than three months, incarcerated individuals, those for whom the lowest cost plan exceeds 8% of the individual's income, and those with incomes below certain tax filing thresholds.

The *employer requirements* mandate coverage for certain employees. There will be an assessment on employers with 50 or more full-time employees that do not offer coverage and have at least one full time employee who receives a premium tax credit. The assessment will be $2,000 per full time employee, excluding the first 30 employees. Employers with 50 or more full time employees that offer coverage but have at least one full time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full time employee (but excludes the first 30 employees from the assessment). Exempted from penalties are employers with up to 50 full time employees. The Act also requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer, though employees may opt out of coverage.

Another aim of The Act is the *expansion of public programs* like Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents and adults without dependent children) with income up to 133% FPL based on modified adjusted gross income. All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. The Supreme Court ruling on the constitutionality of the ACA (discussed more at length later) upheld the Medicaid expansion, but

limited the ability of HHS to enforce it, thereby making the decision to expand Medicaid optional for states.

Additional reforms aim to improve healthcare outcomes and streamline the delivery of healthcare. The strategy is to address *health quality and health system performance* by supporting *effective comparative research.* This would be achieved by establishing a non-profit Patient-Centered Outcomes Research Institute which would identify priorities and conduct research that compares the clinical effectiveness of medical treatments. *Medical malpractice* has been addressed with funding having begun 2011. Preference is given to states that have proposals that are likely to enhance patient safety by reducing medical errors. States are eligible for five-year demonstration grants to develop, implement and evaluate alternatives to current tort litigations. Defects in *Medicare* are being examined with a pilot program begun January 1, 2013. The pilot program must develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post acute-care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot achieves the stated goals of improving or at least not reducing quality, and if spending is reduced, then the pilot would be expanded by January 2016. Coordination of care for *dual eligibles* has been legislated through the creation of a new office within the Centers for Medicare and Medicaid Services, the Federal Coordinated Health Care Office. The office will be charged with more effectively integrating Medicare and Medicaid benefits and improve coordination between the federal government and states. Increased *primary care* fees have been legislated as well. The Act increases Medicaid payments in fee-for-service and managed care for primary services provided by primary care doctors. States will receive 100% federal financing for the increased payment rates.

ACA also focuses on *prevention and wellness* by employing a *National Strategy*. The National Prevention, Health Promotion and Public Health Council is established through the Act. Its job is to coordinate federal prevention, wellness and public health activities. A national strategy to improve the nation's health was due one year after enactment. The Act also creates (upon enactment) a task force on Preventive Services and Community Preventive Services to develop, update, and disseminate evidence-based recommendations on the use of clinical and community preventive services. A Prevention and Public Health Fund is established for prevention, wellness and public health activities including prevention research and health screenings. For the years 2010 through 2015 $7 billion is appropriated and $2 billion each year thereafter. The Act also provides for grants for up to five years to small employers that establish *wellness* programs.

In this paper we discuss various factors that preclude the effective implementation of this legislation and point out not only weaknesses in the legislation, but also the hardship it causes American taxpayers. We examine the mandates as well as the tax implications of this legislation, with the goal of understanding the dimensions of this vast legislation, the parties impacted and compliance requirements. We provide an overview of what must be done to comply with its complex requirements.

BACKGROUND

The Affordable Care Act contains numerous provisions and requirements that impact individuals, insurers, businesses and states. Some of its provisions have had immediate impact while the successful outcome of many other mandates remains untested. ACA mandates *Premium and*

Cost-Sharing Subsidies to Individuals to engage participation. Eligibility requirements are outlined in the legislation. It limits the availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee's share of the premium exceeds 9.5% of income. Refundable and advanceable *premium credits* are provided for and the provisions related to these credits and subsidies are effective January 1, 2014. Verification of both income and citizenship status is required to determine eligibility for the credits.

Premium subsidies to employers are also available. Employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for their employees are provided with a tax credit. The credit is provided in two phases. The first phase is for tax years 2010 through 2013 while the second phase applies to tax year 2014 and later.

To *finance health reform, tax reform related to health insurance* was enacted in the ACA. First, a tax is imposed on individuals without qualifying coverage. In addition, tax benefits have been reduced and taxes have been imposed to increase tax revenues. Tax-favored prescription reimbursement accounts, such as flexible spending accounts (FSAs) have long been used as a tax saving mechanism. Now excluded from tax-free reimbursement are over-the-counter drugs not prescribed by a physician. The law also increases the tax on distributions made from these tax-favored accounts if the distributions are not made for qualifying medical expenses. A new lower limit has been imposed on the amount that may be contributed to a flexible spending account for medical expenses effective January 1, 2013. The tax deduction for unreimbursed medical expenses was for out of pocket expenses in excess of 7.5% of adjusted gross income. That threshold is now raised to 10% of adjusted gross income for tax years 2013 to 2016, except for taxpayers 65 years of age or older. An increase in the Medicare Part A tax of 0.9% is imposed on individuals earning over $200,000 and married couples filing jointly earning more than $250,000, effective January 1, 2013. There is also a 3.8% tax imposed on unearned income for higher income taxpayers. An excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage will be imposed beginning in 2020. The Act also imposes new annual fees on the pharmaceutical manufacturing sector and an annual fee on the health insurance sector. A 2.3% fee on medical devices was imposed beginning effective January 1, 2013. Effective July 1, 2010 a 10% tax has been imposed on indoor tanning services.

Health Insurance Exchanges are created under the ACA. State-based American Health Benefit Exchanges allow individuals and small business with up to 100 employees to purchase qualified coverage. The Small Business Health Options Program (SHOP) allows businesses with more than 100 employees to buy coverage beginning in 2017. Coverage on the Exchanges is available to U.S. citizens and legal immigrants who are not incarcerated. The Office of Personnel Management (OPM) is required to contract with insurers to offer at least two *multi state* plans in each exchange. One plan must be offered by a non-profit entity and one must not provide coverage for abortions beyond those allowed by federal law. To encourage the creation of non-profit, member-run insurance companies, the *Consumer Operated and Oriented Plan (CO-OP)* is created by the law. An organization cannot be an existing health insurer or sponsored by a state or local government in order to receive funding. Four *Benefit tiers* comprise the structure of the Exchanges. The tiers are Bronze, Silver, Gold and Platinum with benefits coverage of 60%, 70%,

80% and 90%, respectively. A Catastrophic Plan is available to those up to the age of 30 or those exempt from the mandate to purchase coverage. Out-of-pocket limits are set at varying levels for those with incomes within discrete brackets up to 400% FPL. The legislation also briefly covers *insurance market and rating rules* as well as *qualifications of participating health plans.* It also mandates certain *requirements for the exchanges* such as maintaining a call center for customer service. Here procedures are to be established for enrolling individuals and businesses. The centers are also responsible for determining eligibility for tax credits. The Act also permits states to establish a *Basic Health Plan* for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. Individuals with incomes within these parameters will not be eligible for subsidies in the Exchanges. The eligible individuals may not pay more than the premiums they would have paid in the Exchanges. Evidently, the Act takes a position on abortion by allowing states to prohibit plans participating in the Exchange from providing abortion coverage. It requires plans that chose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of a woman and in cases of rape or incest) to create allocation accounts to segregate premium payments for coverage of abortion services from premium payments for other services. Provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.

The legislation outlines *Benefit Design*. It considers an *essential benefits package* to be one that provides a comprehensive set of services, limits annual cost sharing, and is not more extensive than the typical employer plan, but prohibits abortion coverage from being required as part of the essential health benefits package. The Act makes *Changes to Private Insurance.* It establishes a *temporary high risk pool* to provide coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants with pre-existing conditions without coverage for at least six months may enroll in the pool and receive subsidized premiums. Effective for plan year 2010, there is a requirement for insurers to report their *medical loss ratio.* Health plans must report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to customers for the amount of premium spent on clinical services and quality that is less than certain thresholds. The Act also establishes a process for p*remium rate reviews* in order to justify increases. ACA mandates *dependent coverage* for children up to age 26 for all individual and group policies. This provision became effective six months after the legislation was signed. *Insurance market rules* are set by the Act. It prohibits individual and group plans from rescinding coverage, except in cases of fraud. Pre-existing condition exclusions for children is now prohibited. Effective January 1, 2014, these plans cannot place annual limits on the dollar value of coverage. All new policies (except stand-alone dental, vision and long-term care) must comply with one of the four benefit categories. The Act also places some limits on deductibles and limits the waiting period for coverage to 90 days. In the *Consumer protection* realm, ACA mandates establishment of an internet website to help identify health coverage options. Development of standards for insurers to use in providing information on benefits and coverage is also mandated. *Health Insurance Administration* is funded with $1 billion. This money is being used by the newly established Health Insurance Reform Implementation Fund within HHS to implement health reform policies.

The *State Role* mandate centers around creation of the Exchanges, changes in Medicaid, and providing consumer assistance. *Cost Containment* in the Act focuses on *administrative simplification* and *Medicare* reform. For example, payments to Medicare Advantage plans are restructured to set payments to different percentages of Medicare fee-for-service rates. It also freezes the threshold for income-related Medicare Part D premium subsidies for those in higher income brackets, effective January 1, 2011. A Payment Advisory Board is established by the

Act. Medicare Disproportionate Hospital Payments are reduced 75% effective 2014 while increasing payments based on the percentage of the population uninsured. Also reduced are Medicare payments made to hospitals for excess/preventable readmissions and those for hospital-acquired conditions. In the area of *prescription drugs* ACA authorizes the Food and Drug Administration (FDA) to approve generic versions of biological drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of most of the ACA in the case *National Federation of Independent Business v. Sebelius.* In a 5-4 decision the Supreme Court ruled that Congress does not have authority under the Commerce Clause of the U.S. Constitution to require individuals to own a minimum level of insurance but does have the authority to use its taxation authority to impose a coverage mandate. The court narrowed the scope of a provision dealing with state Medicaid program expansion requirements, forbidding the government from taking existing Medicaid funding away from states that fail to comply. Chief Justice Roberts wrote in an opinion for the majority that the imposition of a tax "leaves an individual with a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice....[and]…. The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."

THE PROBLEM

According to Deloitte, one of the Nation's big four accounting firms, the signing of PPACA brought on a new era of government intervention in the healthcare marketplace. Large employers need to understand various aspects of the legislation, including health plan design, compliance, tax concerns, change in employee health benefit administration systems, and employee awareness. Also impactful are new eligibility and coverage provisions and potential "grandfather" provisions.

The executive director of Deloitte's Center for Health Solutions, Dr. Paul Keckley, believes there are uncertainties about the law, most importantly with respect to providers and consumers. First, is the question as to whether states can do everything required of them. States must decide if they want to expand the Medicaid program to millions of new eligible people. Secondly, it is unclear if younger people will sign up for health insurance via the Exchanges. Individuals who do not enroll are subject to either a fixed amount tax or a percentage of income tax. The penalty is a flat $95 per person tax in 2014, $325 in 2015 and $695 in 2016. Notwithstanding, younger folks may not feel compelled to enroll. Younger, healthier enrollees are needed to help lower costs for those with more costly chronic conditions. The third variable is the impact of the Exchanges. There is fear (rather, a reality) that the Exchanges encourage employers to stop offering health insurance altogether, leaving employees at the mercy of the Exchanges. It is less costly for employers to follow this route than to pay the high cost of premiums. Finally, the question of consolidation emerges. Since the law's inception, there has been significant consolidation within the industry. Usually, consolidation in the hospital industry, for instance has not resulted in reduced costs. It remains to be seen whether in fact this will be the case as the impact of the law plays out.

Another big four accounting firm, KPMG, issued a Brief following the Supreme Court's decision on the PPACA. In the brief the KPMG Government Institute along with the KPMG Global

Human and Social Services Center of Excellence narrow the issues related to Medicaid expansion to five. The first is whether states should move forward with Medicaid expansion. It is optional and can cost hundreds of millions of dollars. States will require an estimate of the cost impact and should compare that with the state's existing cost of coverage for the uninsured. This analysis will assist the state in assessing costs and benefits of moving forward with the expansion. Second, if a state does not opt for expansion, what happens to those between the state's existing Medicaid threshold and 100% FPL? Are they eligible for subsidies? KPMG considers that these families may not even be able to afford the subsidized premium. The writers suggest the state and federal government together address this issue of affordability. Related to this issue is the third question of the brief and it relates to whether there could be a tax assessed on those uninsured falling into a gap between the traditional Medicaid program and the subsidized market. Again, KPMG recommends that the state and federal government iron this out. The fourth concern is the ACA's anticipated cost "saver" which would be realized as a result of the phase-out of the Disproportionate Share Hospital (DSH) payments. The phase-out, triggered by a reduction in the uninsured population, would have resulted in a reduction by at least 50% in a state's DSH allotment. However, if the trigger is not met, the reduction will not occur. Finally, the brief introduces the risk that critical mass needed to make the program economically feasible may not be achieved. This could occur because the newly insured would otherwise have been enrolled in Medicaid. If the program is not expanded, the uptake into a Health Benefit Exchange (HBE) would be significantly reduced and critical mass needed for the financial health of the program would not be achieved. Analysis should be conducted to determine if a state-based exchange continues to be a viable option.

Grave concerns have also been voiced by many regarding the negative effects of the health care law on employment and consumer spending. Both will emerge as issues in 2014 when consumers react to ACA-driven changes in the cost of health insurance, and small business owners grapple with the employer mandate. Health insurers are likely to raise premiums for 2015 for customers obtaining insurance through the new health care exchange. Fewer young, healthy people are likely to buy insurance through the new exchange than the government originally had anticipated. While older and sicker people who need to cover pre-existing conditions will likely get coverage through the Exchange, a larger-than-expected fraction of young and healthy people will likely pay the penalty for non-insurance. The end result will be an older and sicker risk pool than policy makers had hoped for, which will cause insurers to raise premiums for 2015. Once Americans can sign up for health insurance online, many of them will find out that the plans they can purchase have high deductibles. Those deductibles, combined with notices of rising premiums (which will be sent out by insurers sometime in 2014), will strain consumers' household budgets. This sticker shock will dampen consumer spending (probably in the second half of 2014), just as big retailers like Wal-Mart are now predicting.

As small businesses prepare for the employer mandate, they will cut hiring and trim workers' hours. Because companies with 50 or more employees now need to offer health care coverage to full-time workers, businesses will cut some worker hours to part-time levels. Recent surveys by the International Franchise Association and the U.S. Chamber of Commerce, the International Foundation of Employee Benefit Plans (IFEBP) and the Gallup Organization indicate that between 12 and 18 percent of employers have already begun converting full-time jobs to part-time in response to the new law. Those numbers are expected to grow as the start of the employer mandate approaches. Unable to absorb the cost of employee health insurance, small businesses in low margin industries will cut hiring. The IFEBP survey showed that 7 percent of small companies have already cut employment in response to the law, while the Gallup poll indicated that 19 percent have trimmed their workforce. Future hiring plans will also be trimmed. More

than four-in-ten respondents to the Gallup poll said they "have held off on plans to hire new employees" and nearly four-in-ten "have pulled back on plans to grow their business" in response to the ACA. One-in-four small businesses has indicated that they will "reduce hiring" in response to the new law. The layoffs and hiring cuts will be concentrated among businesses with just under 50 employees, as companies seek to keep their work forces below the cut-off at which they have to offer employee health insurance. The IFA-Chamber survey reveals that more than half (52 percent) of businesses with between 40 and 70 employees plan to "make personnel changes" to remain below 50 workers. Some companies will respond to the law by dropping employee health insurance. The IFA-Chamber survey indicates that more than one quarter (28 percent) of businesses surveyed will drop employee health insurance coverage and pay the penalty for non-insurance in 2015, when the employer mandate begins. While the termination notices and problems with the health care exchange website have plagued the Obama Administration in 2013, the major economic costs of the new health care law will not become apparent until later in 2014 as the impact of these changes are felt.

Indeed, a major player in the medical device industry, Boston Scientific, notes in its annual report that it is "unclear what the full impact will be from the law." The 2.3% tax is imposed on medical devices such as CAT scans machines, stents, defibrillators, and other devices sold to hospitals and other health care providers. Regardless of where the item is manufactured, the tax is imposed on sales made in the U.S. One study indicates that the tax could result in job losses in excess of 43,000 and that manufacturers will be more likely to close plants in the U.S. and replace them with overseas operations.

The government website which caused considerable angst in the Fall of 2013 has sprouted yet another surprise for enrollees: unaffordable deductibles. The average individual deductible for the lowest priced coverage, the bronze plan, is $5,081. The result may be that sick individuals will not seek treatment in order to avoid paying the high deductible. Many policyholders whose old plans were cancelled because they didn't meet the coverage standards of ACA are facing higher prices on the Exchanges. Now they will face higher deductibles, too.

CONCLUSION

According to Deloitte, U.S. employers are concerned about rising healthcare costs and unaware of solutions that could improve the safety and quality of care while reducing costs. Deloitte's survey of employers offering health benefits and with 50 or more employees indicates that employers feel they have a good understanding of the PPACA, but were not well prepared (back in late 2012) to implement the 2014 provisions. Fifty-nine percent felt the Act is a step in the wrong direction, and that across-the-board government spending cuts are a higher priority than changes to the healthcare system. When considering healthcare strategies to reduce the deficit, employers favor repeal/delay of PPACA. Employers consider increased cost sharing with employees to be the optimal strategy in dealing with rising healthcare costs.

KPMG has also weighed in on its view of the impact of the ACA. The Supreme Court ruling should make states lean more toward getting exchange services from the federal government. The Court ruled that Congress has no authority to reduce existing Medicaid funding to make states expand their Medicaid programs to provide coverage for those earning less than 133% FPL. Officials in some states say that they will try to expand Medicaid access despite the ruling while other states plan to block PPACA implementation including implementation of the Medicaid

expansion program. PPACA may set up exchanges that would help low-income individuals get access to government health insurance programs such as Medicaid. Higher income individuals and small businesses use new tax subsidies to buy commercial health coverage. HHS will provide Exchange services where states do not set up Exchanges by January 1, 2014. KPMG analysts propose whether a state that decides not to expand Medicaid access to the required level should consider operating a state-based health insurance exchange. Their belief is that the majority of newly insured would have been enrolled in Medicaid under the expanded program. If the program is not expanded, the remaining population may not provide the critical mass necessary to warrant a state-based exchange or make it economically sustainable.

It is clearly evident that in spite of the good intentions of the legislation, there remain many unanswered questions, and extensive risks to employers, employees, states, insurers and the economy. A well thought out piece of legislation might have broached these risks in a measured way rather than waiting to react to them.

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